

State of Wyoming



Department of Health

Rules and Regulations for Waiver Provider Certification and Sanctions

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Chapter 45

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CHAPTER 45

WYOMING MEDICAID RULES

WAIVER PROVIDER CERTIFICATION AND SANCTIONS

Section 1. Authority.

This Chapter is promulgated by the Department of Health pursuant to W.S. § 9-2-102, the Medical Assistance and Services Act at W.S. §§ 42-4-104 and 42-4-120, 2013 Wyoming Session Laws 322-325, and the Wyoming Administrative Procedure Act at W.S. §§ 16-3-101 through 16-3-115.

Section 2. Purpose and Applicability.

(a) This Chapter was adopted to govern certification of providers under the Wyoming Medicaid Adult Developmental Disabilities Home and Community Based Waiver, the Children's Developmental Disabilities Home and Community Based Waiver, the Supports Waiver, the Comprehensive Waiver, and the Acquired Brain Injury Waiver (herein collectively referred to as the "DD Waivers").

(b) The Behavioral Health Division, hereafter referred to as the "Division," may issue Provider Manuals, Provider Bulletins, or both, to providers and/or other affected parties to interpret the provisions of this Chapter. Such Provider Manuals and Provider Bulletins shall be consistent with and reflect the rule provisions policies, as revised in this Chapter. The provisions contained in Provider Manuals or Provider Bulletins shall be subordinate to the provisions of this Chapter.

(c) The incorporation by reference of any external standard is intended to be the incorporation of that standard in effect on the effective date of this Chapter.

Section 3. General Provisions.

(a) Terminology. Unless otherwise specified or as defined in Chapter 1, the terminology used in this Chapter is the standard terminology and has the standard meaning used in accounting, health care, Medicaid and Medicare.

(b) The requirements of Title XIX of the Social Security Act, 42 C.F.R. § 441.1 Subpart G, and the Medicaid State Plan apply to Medicaid and are incorporated by this reference as of the effective date of this Chapter, and may be cross-referenced throughout this Chapter where applicable. This incorporation by reference does not include any later amendments or editions of the incorporated matter. The incorporated rules and regulations may be viewed at <http://www.ecfr.gov/cgi-bin/ECFR>. The Medicaid state plan may be viewed at <http://www.health.wyo.gov/healthcarefin/medicaid/spa.html>. These materials may be obtained at cost from the Department.

Section 4. Rights of Participants Receiving Services.

(a) Each participant receiving services has the same legal rights and responsibilities guaranteed to all other U.S. citizens under the United States and Wyoming constitutions and federal and state laws.

(b) Participant rights may not be modified or suspended except in accordance with state or federal law, this includes modifications to rights specified in court orders including, but not limited to, guardianship, conservatorship, probation or parole orders.

(c) The following participant rights may not be denied or limited except for the purpose of health and safety and as part of the participant's individual plan of care. The participant, the participant's legally authorized representative(s), the participant's case manager, and the Division shall be informed in writing and orally of the grounds for the denial or limitation. Such notice shall include a statement that the participant may choose an alternative provider if the participant disagrees with the denial or limitation. Rights restrictions shall constitute a material change to the plan of care, requiring re-approval by the Division.

- (i) The right to send and receive unopened mail;
- (ii) The right to choose and wear one's own clothing;
- (iii) The right to keep and use one's personal possessions;
- (iv) The right to keep and spend money;
- (v) The right to privacy in matters of toileting and bathing;
- (vi) The right to make and receive telephone calls;
- (vii) The right to receive visitors daily;
- (viii) The right to an appropriate personal space that provides privacy and personal safety;
- (ix) The right to choose where and with whom to live;
- (x) The right to present grievances and complaints to the provider or to request changes in the provider's policies to the provider,
- (xi) The right to request changes in the one's individualized plan of care;

(d) The following participant rights may not be denied or limited unless a court, the participant, or the participant's legally authorized representative authorize the denial in writing. Such denial or limitation shall be included in the participant's plan of care, and the authorizing document shall be made part of the participant's individual plan of care:

- (i) The right to vote;

(ii) The right to present grievances and complaints to the Division, the Department of Health, the Department of Family Services, Protection and Advocacy, or any other law enforcement or participant advocacy organization;

(iii) The right to be free from physical, mechanical, and chemical restraints except as otherwise provided by this Chapter.

(e) Procedural requirements regarding rights. A provider shall have and implement policies and procedures that ensure:

(i) Except as identified in this section, participants have the opportunity to maximize their rights and responsibilities.

(ii) All participants have the right to refuse services and may not be disciplined or charged with a monetary fee for refusing services.

(iii) Each participant served, parent of a minor, or legally authorized representative(s) is informed of the participant's rights and responsibilities:

(A) The information must be given at the time of entry to services, annually thereafter, and when significant changes occur; and

(B) The information must be provided in a manner that is easily understood, given verbally and in writing, in the native language of the participant or legally authorized representative(s), or through other modes of communication necessary for understanding.

(iv) Participants receiving services from the provider are supported in exercising their rights;

(v) Rights may not be treated as privileges or things that should be earned; and

(vi) Retaliation is prohibited against participants' services and supports due to the participant, family members, or legal representatives advocating on behalf of the participant. This includes initiating a complaint with outside agencies.

(f) Providers may not request or require participants to waive or limit their rights as a condition of receiving service.

(g) Providers may not intimidate, threaten, coerce, discriminate against, or take other retaliatory action against any individual for the exercise by the individual of any right established, or for participation in any process provided for, by these rules or the Wyoming Medical Assistance and Services Act.

Section 5. Provider Qualifications for Each Waiver Service.

(a) To be a certified waiver provider or an employee of a provider for a specific service, the provider or employee shall complete and maintain the following requirements unless otherwise specified in this section:

(i) Be eighteen (18) years or older;

(ii) Maintain current CPR and First Aid Certification, which includes hands-on training from a trainer certified through the American Heart Association or the American Red Cross.

(b) A provider shall also meet the following specific requirements for the service in which they want to receive and maintain certification:

(i) Adult Day Services. A provider of Adult Day Services shall be either:

(A) An agency certified to provide Adult Day Services, or

(B) A provider with a license for an Adult Day Care as provided by the Wyoming Department of Health, Office of Healthcare Licensing and Surveys.

(ii) Behavioral Support Services. A provider of Behavioral Support Services shall have either:

(A) A Master's Degree and be a Board Certified Behavior Analyst or have a similar nationally recognized certification in positive behavior supports with approval from the Division, or

(B) A current license to practice Psychology from the Wyoming Board of Psychology and have specific training on positive behavior supports from a nationally recognized organization.

(iii) Case Management.

(A) After the effective date of this rule, all providers of case management services must have one (1) of the following:

(I) A Master's degree from an accredited college or university in one (1) of the following related human service fields:

(1.) Counseling,

(2.) Education,

(3.) Gerontology,

(4.) Human Services,

- (5.) Nursing,
- (6.) Psychology,
- (7.) Rehabilitation,
- (8.) Social Work,
- (9.) Sociology, or
- (10.) A related degree, as approved by the Division.

(II) A Bachelor's degree in one (1) of the related fields from an accredited college or university, and one (1) year work experience as a case manager or in a related human services field.

(III) An Associate's degree in a related field from an accredited college, and four (4) years of work experience as a case manager or in a related human services field;

(B) A case manager employed by an agency or certified prior to the effective date of this rule may continue to provide case management services, without meeting the criteria in subsection (b)(iii)(A), as long as the case manager demonstrates reasonable and ongoing efforts to obtain the required qualifications during a three-year transition period from that date.

(I) The Division shall accept 60 credit hours with at least 24 credit hours in a related field and five (5) years of work experience as a case manager on any of the Wyoming waivers as an exception for not meeting the required education requirements in (b)(iii)(A) of this section.

(II) Persons seeking to qualify as a case manager under this section shall obtain the additional education requirements prior to January 1, 2018.

(III) The Division shall terminate a case manager who fails to obtain the required education.

(C) A case manager shall obtain and maintain his or her own National Provider Identifier (NPI) number for case management services through the Medicaid enrollment process.

(D) A provider agency certified to provide case management services shall:

(I) Have policies and procedures for backup case management for each person's caseload and meet with their designated backup to review all participant cases on a quarterly basis, with the review documented in case notes.

(II) Have each case manager obtain proof of competency demonstrated through successful completion of the Division-approved case management training curriculum initially and annually.

(III) Document on the plan of care that they have no conflict of interest with the participant or family.

(IV) Meet the following conflict free requirements:

(1.) The case management agency and any managing employee may not own, operate, be employed by, or have a financial interest in or financial relationship with any other person or entity providing services on the participant's individual plan of care.

(2.) The case management agency may be certified in other waiver services, but shall not provide case management services to any participant that they are providing any other waiver services to, including self-directed services.

(3.) The case manager or case management agency may not serve any participant that receives waiver services from a waiver provider if any of the provider's owners, officers, or managing employees are related by blood or marriage to a case manager or any managing employee of the case management agency.

(4.) Any employee of a guardianship agency may not provide case management to any participant who is receiving any services from the guardianship agency.

(5.) Also, a case management agency may not:

a. Employ case managers that are related to the participant, the participant's guardian, and/or a legal representative served by the agency. If the case management agency is a sole proprietor, the case manager may not be related to the participant, the participant's guardian, or a legal representative served by the agency;

b. Make financial or health-related decisions on behalf of the participant receiving services from that agency, including but not limited to a guardian, representative payee, power of attorney, conservator or other position as defined by the Division; or

c. Provide case management services to, or live in the same residence of, any provider on a participant's plan in which they provide case management service.

(V) If a rural area of the State does not have a case manager without a conflict of interest for a participant, the participant or legally authorized representative may request to have a case manager with a conflict. If:

(1.) The Division confirms that there are no other case managers available in the region or a nearby region to provide case management, then the conflicted case manager may be approved on an annual basis.

(2.) A third party entity without a conflict shall be involved in the participant's team to mediate, advocate for the participant as needed, and address unresolved grievances for any conflicts that are approved.

(3.) This approval shall be subject to notice to and approval by the Centers for Medicaid and Medicare Services.

(iv) Child Habilitation. Any Child Habilitation provider operating a day care shall follow the Department of Family Services licensing rules, if operating a day care while providing child habilitation services to a participant.

(v) Cognitive Retraining. A Cognitive Retraining provider shall:

(A) Be certified in Cognitive Retraining from an accredited institution of higher learning, or

(B) Be a certified Brain Injury Specialist through the Brain Injury Association of America, or

(C) Be a licensed professional with one year of acquired brain injury training or Bachelor's degree in related field and three (3) years of experience in working with acquired brain injuries.

(vi) Community Integration Services. Within one (1) year of being certified in this service, a Community Integration Services provider shall have at least one (1) staff person working at least half of their time as a supervisor for staff performing community integration services certified in a nationally recognized supported employment curriculum. The supervisor shall be able to demonstrate that a portion of their time each month is spent training direct care staff on exploring employment interests, working on job readiness skills, or other employment related activities with participants.

(vii) Crisis Intervention Support. A Crisis Intervention Support provider shall:

(A) Within one year of certification in this service, an accredited provider serving more than five (5) participants with restraints or restrictive interventions in their plans are required to have a supervisor successfully complete positive behavior support curriculum through a nationally recognized positive behavior support curriculum approved by the Division.

(B) An additional supervisor shall be certified for every ten (10) additional participants with restraints or restrictive interventions in their plan.

(C) CPI or MANDT training is not sufficient to meet these requirements.

(viii) Dietician. A Dietician provider shall have a license to provide dietician services by the Wyoming Dietetics Board.

(ix) Environmental Modification. An Environmental Modification provider shall have a building, electrical and plumbing contractor, City Contractor's License, State Electrician's License, or applicable bonding information as may be required to work as a contractor in the location where services will be provided.

(x) Employment Discovery and Customization. Within one year of becoming certified in employment services, the Employment Discovery and Customization provider shall

have one (1) employee certified in a nationally recognized supported employment curriculum approved by the Division for every ten (10) participants served. The employee certified shall work at least half of their time as a job coach or job developer.

(xi) Independent Support Broker. An Independent Support Broker shall pass a competency based test from the Division prior to providing the service and have either:

(A) One (1) year of experience in the field of ID/DD and a Bachelor's degree, Master's degree or Doctoral degree, or

(B) Two (2) years or 48 credit hours of college and two (2) years of experience.

(xii) Individual Habilitation Training. Within one (1) year of being certified in this service, and annually thereafter, the provider or staff providing the service shall successfully complete at least eight (8) hours of continued education in any of the following areas: specific disabilities or diagnosed conditions relating to the population served, writing measurable objectives, gathering and using data to develop better training programs, or training modules posted by the Division.

(xiii) Occupational Therapy. An Occupational Therapy provider shall have a current license to practice occupational therapy by the Wyoming Board of Occupational Therapy.

(xiv) Physical Therapy. A Physical Therapy provider shall have a current license to practice physical therapy by the Wyoming Board of Physical Therapy.

(xv) Prevocational. Within one (1) year of certification in prevocational services, a provider shall have one (1) staff person working at least half of their time as a supervisor of this service. The supervisor shall be certified in a nationally recognized supported employment curriculum and demonstrate that a portion of their time each month is spent training direct care staff on exploring employment interests, working on job readiness skills, or other employment related activities with participants.

(xvi) Skilled Nursing. A skilled nursing provider shall have a current RN License or greater from the Wyoming State Board of Nursing.

(xvii) Special Family Habilitation Home. A Special Family Habilitation Home provider shall be at least 21 years of age or older.

(xviii) Specialized Equipment. A Specialized Equipment provider shall have the applicable license or certification for the type of equipment purchased for a participant.

(xix) Speech, Hearing, and Language Services. A Speech, Hearing, and Language Service provider shall have a current license to practice Speech, Hearing and Language Services by the Wyoming Board of Speech Pathology and Audiology.

(xx) Supported Employment. A Supported Employment provider shall, within one (1) year of becoming certified in employment services, have one (1) employee working at least half of their time as a job coach or job developer that is certified in a nationally recognized supported

employment curriculum approved by the Division for every ten (10) participants served in this service.

(xxi) Transportation. A Transportation provider shall have a current, valid, Wyoming driver's license; automobile insurance; and additional liability insurance for transporting people for business purposes.

Section 6. Provider Agency Standards.

(a) Consistent with the provisions of this chapter, providers shall:

(i) Protect participants from abuse, neglect, mistreatment, intimidation, and exploitation;

(ii) Treat participants with consideration, respect, and dignity;

(iii) Honor participants' preferences, interests, and goals;

(iv) Provide participants with daily opportunities to make choices and participate in decision making;

(v) Provide activities that are meaningful and functional for each participant;

(vi) Direct services toward maximizing the growth and development of each participant for maximum community participation and citizenship;

(vii) Provide services in the most appropriate, least restrictive, most integrated environment;

(viii) Allow participants to express their wishes, desires, and needs.

(ix) Protect and promote the health, safety, and well-being of each participant;

(x) Design services to meet the needs of all participants served by their agency; and

(xi) Establish and implement written policies and procedures that are:

(A) Available to staff, participants, and the general public;

(B) Updated or revised as needed by rule or policy changes,

(C) Reviewed at least annually with employees; and

(D) Describe the provider's operation and how systems are set up to meet participants' needs.

(b) Providers shall establish and implement a quality assurance process for:

- (i) Ongoing proactive internal review of the quality and individualization of services;
 - (ii) Continuous quality review of the services provided;
 - (iii) Providing evidence that participants served and their families are involved in the quality assurance process.
- (c) Before providing services to a participant, the provider shall gather and review referral information regarding the participant so, to the greatest extent possible, the provider is aware of the participant's preferences, strengths, and needs. The provider shall use this information to:
- (i) Make a determination as to whether their agency is capable of providing services to meet the participant's needs;
 - (ii) Consider the safety of all participants who the provider serves in the decision to accept new participants to service or the location for the services; and
 - (iii) Consider whether the provider has the capacity, commitment, and resources necessary to provide supports to the participant served.
 - (iv) The provider may not serve a participant if the provider cannot reasonably assure that it has the ability to meet the participant's needs.
- (d) The provider shall recruit, orient, train, manage, and retain qualified staff with the skills necessary to meet the needs of participants in their services and be able to respond to emergencies.
- (e) The provider shall ensure that all participants receive the services detailed in the plan of care, including the habilitation, supports, health care, and other services consistent with the needs and preferences of the participant.
- (f) The provider shall develop a system to detect and prevent abuse, neglect, exploitation, and intimidation and to handle allegations of abuse, neglect, exploitation and intimidation in accordance with state and federal statutes and rules.
- (g) The provider shall, at all times, maintain documentation to ensure sufficient staff provide services, supports, and supervision to meet the needs of each participant per the participant's plan of care.
- (h) The provider shall implement reasonable and appropriate policies and procedures to comply with the standards, specifications, and requirements of this chapter. Compliance with this provision does not permit or excuse a violation of any standard, specification, or requirement of this chapter. A provider may change its policies or procedures at any time, provided that the changes are documented, implemented, and maintained in accordance with the standards, specifications, and requirements of these rules.

(i) If a provider subcontracts with another provider, individual, or entity for provision of waiver services, that provider shall remain responsible to the Department and Division for the subcontractors compliance with these rules.

(j) The provider shall disclose to the Division any subcontractor relationship prior to providing waiver services to ensure compliance with Division requirements.

Section 7. Provider Recordkeeping and Data Collection.

(a) The provider shall collect and maintain data and information as necessary to provide services. The provider shall, upon request or requirement, submit data and other required information in the manner requested, to the Department or other federal, state, or local regulatory entities.

(b) The provider shall develop and maintain a record keeping system that includes a separate record for each participant served.

(c) The provider shall develop and implement a systematic organization of records to ensure permanency, accuracy, completeness, and easy retrieval of information.

(d) The provider shall develop a process relating to retention, safe storage, and safe destruction of the participant's records to ensure retention of necessary information and to protect confidentiality of records. The provider shall retain all records relating to the participant and the provision of services for at least six (6) years.

(f) If there are changes in ownership of the provider agency, complete and accurate copies of all participant records must be transferred to the participant's newly chosen provider. Before dissolution of any provider agency, the provider shall follow Medicaid disenrollment procedures and notify the Division in writing of the location and secure storage of any remaining participant records.

(g) The provider shall establish and implement policies that govern access to, duplication, dissemination, and release of information from the participant's record, which are consistent with applicable state and federal laws.

(h) Except as otherwise provided by law, the provider shall obtain a written authorization from the participant or the participant's legally authorized representative for the release of participant information that identifies or can readily be associated with the identity of a participant. The authorization must comply with the requirements for hospital records identified in W.S. § 35-2-607.

(i) Providers shall make all records maintained or controlled by the provider available to the Division Staff, representatives from the State or Federal Medicaid programs, or the Medicaid Fraud Control Unit, without prior written authorization, consent, or other form of release.

(j) The provider shall specify the method and frequency for obtaining authorizations for medical treatment and consents.

(k) The provider shall ensure that all record entries are dated, legible, and clearly identify the person making the entry.

Section 8. Documentation Standards.

(a) In addition to the requirements of with Chapter 3, Provider Participation, of the Wyoming Medicaid Rules, the following provisions shall apply to the documentation of services, medical and financial records, including information regarding dates of services, diagnoses, services furnished, and claims affected by this Chapter.

(b) A provider shall complete all required documentation, including the required signatures, before or at the time the provider submits a claim.

(i) Documentation prepared or completed after the submission of a claim is prohibited. The Department shall deem the documentation to be insufficient to substantiate the claim and Medicaid funds shall be withheld or recovered.

(ii) Documentation may not be altered in any way once billing is submitted unless the participant or legally authorized representative requests an amendment to the documentation in accordance with the patient privacy rules in the Health Insurance Portability and Accountability Act of 1996.

(c) A provider shall document services either electronically or in writing.

(d) Electronic documentation shall capture all data required by subsection (e) and include electronic signatures, automatic date stamps, and automated tracking of all attempts to alter or delete information that was previously entered.

(i) Electronic records may not be altered or deleted unless incorrect and the purpose of the correction must be captured in the electronic documentation system.

(ii) If anyone other than the employee who provided the service completes electronic documentation for the purpose of claims submission, the provider shall separately maintain all written or electronic service documentation to support the claim.

(e) For written documentation, each physical page of documentation must include:

(i) Full legal name of participant;

(ii) Individualized plan of care date for participant;

(iii) Location of services;

(iv) Date of service, including year, month, and day;

(v) Type of service provided;

(vi) Time services begin and time services end using either AM and PM or military time and documenting per calendar day, even when services are provided over a period longer than one calendar day;

(vii) Printed name of person performing the service;

(A) At least one legible signature of each person performing a service, and the date of signature. Initials may subsequently be used on any page that bears the staff person's full signature; and

(viii) For services other than case management or therapies, the documentation shall include a detailed description of services provided and:

(A) Consist of a personalized list of tasks or activities that describe a typical day, week, or month for a participant.

(B) Reflect the desires of the participant.

(C) Include details on specific objectives for habilitation services, support, health and safety needs, preferred activities, and approximate number of hours in service.

(f) For self-directed services, the employee hired shall include all components listed in subsection (e)(i) through (e)(iii) with a summary of the activities included during the provision of services delivered.

(g) Documentation does not have to be on separate forms, but must clearly be separated by time in and out, service name, documentation of services provided, signature of staff providing services, and printed name of staff providing the service.

(h) One (1) provider employee may not provide more than one waiver service at the same time.

(i) A provider organization may not bill for the provision of more than one service for the same participant at the same time unless the participant's approved individualized plan of care identifies the need for more than one (1) service to be provided at the same time.

(j) A provider may not round up total service time to the next unit unless it is a skilled nursing service. A skilled nursing service unit may be provided for up to fifteen (15) minutes and must involve one-on-one direct patient care. Units billed for rounded up services may not exceed eight (8) units within a one hour timeframe for multiple participants in a single location by one provider nurse.

(k) Documentation of services must be legible and retrieved easily upon request.

(l) Services must meet the service definitions in these rules and be provided pursuant to a participant's individualized plan of care.

(m) Any temporary change or deviation from the plan of care must be documented by the provider or provider staff and kept in the participant's file. The provider must notify the case

manager of temporary changes or deviations from the plan that occurred during the month when monthly documentation is submitted, so the plan of care can be modified, if necessary.

(n) For all direct care waiver services, the participant shall be in attendance in the service in order for the provider to bill for services.

(o) The provider shall submit service documentation and billing information for services rendered to the case manager each month by the tenth (10th) calendar day of the month following the date that the services were rendered. If services are not delivered during a month, the provider shall report the zero units used to the case manager by the tenth (10th) calendar day of the following month.

(i) Failure to submit documentation by the tenth (10th) calendar day of the month may result in a corrective action plan, full recovery of funds, or sanctioning.

(ii) The case manager shall give written notification of noncompliance to the provider with a copy submitted to the Behavioral Health Division. Chronic failure to submit documentation may result in provider sanctions.

Section 9. Case Management Services.

(a) Case management is a mandatory service to all participants enrolled on the waivers.

(b) A case manager shall use person-centered planning to understand the needs, preferences, goals, and desired accomplishments of the participant. The case manager shall coordinate and assist the participant in accessing all resources, such as natural, paid, and community support available and needed. Finally, the case manager shall develop and monitor the implementation of an individualized plan of care.

(c) The case manager shall know the current physical and mailing addresses of the participant's and legally authorized representative(s) at all times and update the Division and other providers in a timely manner as there are changes.

(d) The case manager shall maintain a participant's file and service documentation:

(i) The case manager shall assure information is disseminated to appropriate parties involved in the participant's care or as authorized by a signed release of information by the participant or the participant's legally authorized representative(s);

(ii) The case manager shall arrange and coordinate eligibility for applicants, or waiver participants, by providing:

(A) Targeted case management services to an applicant who is in the eligibility process for waiver services or awaiting a funding opportunity.

(B) Services that include the coordination and gathering of information needed for initial, annual clinical, financial eligibility determination, and the level of care determination.

(iii) Provide the participant and any legally authorized representative(s) with a list of all providers available to their community in order to allow the participant a choice of providers. To the extent that they are available, participant choice shall include any certified waiver provider, self-directed options, Medicaid state plan services, services offered by other state agencies, as well as community and natural supports.

(A) At least once every six (6) months, the case manager, shall provide information to the participant or the legally authorized representative(s) on all available waiver services, including self-direction service delivery options. This may be done more frequently as requested by the participant or legally authorized representative(s).

(B) The case manager shall assist in coordinating transition plans which the participant chooses to change, stop, or add providers to his or her plan of care or exit the waiver.

(C) If the case manager chooses to stop providing services, the case manager shall give thirty (30) days written notice of the change to the participant or legally authorized representative(s), and to the Division, and continue to provide case management services for the thirty (30) days or until a new case manager is approved, whichever is first.

(iv) The case manager shall involve and assist the participant's identified team members with developing a person-centered plan of care in accordance with this Chapter. The case manager shall assist the team with planning, budgeting and prioritizing services for the participant using all available resources and the assigned individual budget amount.

(v) The case manager shall complete and submit the individualized plan of care for Division approval in the electronic Medicaid waiver system, or its successor, at least thirty (30) days before the intended plan start date, including all the required components.

(vi) If the participant chooses to self-direct services on the waiver, the case manager shall assist the participant in finding a support broker, modifying the plan of care as needed, and monitoring the services of the Financial Management Service utilized by the participant to self-direct in accordance with the approved waiver.

(vii) The case manager shall ensure all providers on the participant's plan of care sign off on the plan, receive a copy of the plan, and complete participant specific training as required in Section 15 of this Chapter.

(viii) The case manager shall monitor and evaluate the implementation of the participant's individualized plan of care including a review of the type, scope, frequency, duration, and effectiveness of services, and the participant's satisfaction with the supports and services. Results must be documented in the master record and be made available to the Division upon request. After the evaluation, the case manager shall:

(A) Report any concerns with provider implementation of the individualized plan of care or concerns with the health and safety of a participant to the provider. Significant concerns shall be reported to the Division through the incident reporting or complaint processes.

(B) Send the provider or employer of record and the Division written notification of noncompliance with these rules, the plan of care, or when documentation is not received by the tenth (10th) working day of the following month after services were provided.

(C) Retain and securely store all confidential provider documentation received from other providers for a participant's services for a twelve (12) month period from the month services were rendered, even if the participant changes case managers.

(D) Document all monitoring and evaluation activities, follow-up on concerns and actions completed, and make appropriate changes to the plan of care team involvement, as needed.

(e) A case manager shall be the second-line monitor of medications for participants receiving medications. The case manager shall report all medication errors, which were not reported by the provider, to the Division.

(f) The Division may establish caseload limits to ensure the case manager effectively coordinates services with all participants on his or her caseload.

Section 10. Individualized Plan of Care.

(a) A participant's case manager shall convene a participant's plan of care team to develop an individualized plan of care for each participant on his or her caseload, and base the plan on the results of the comprehensive assessment(s), and the person-centered planning process. The team shall include persons who are knowledgeable about the participant, and are qualified to assist in developing an individualized plan of care for that person, including: the participant; any legally authorized representative(s); the case manager; providers chosen by the participant; and any other advocate, family member, or entity chosen by the participant or the participant's legally authorized representative(s).

(b) The plan of care cannot exceed twelve (12) months and must be developed in accordance with state and federal rules and Division policy, and, at a minimum, must include the provision of or describe the inability to provide;

(i) Necessary information and support to the participant to ensure that the participant directs the process to the maximum extent possible;

(ii) Services in a setting chosen by the participant;

(iii) Opportunities for the participant to seek employment and work in competitive integrated settings;

(iv) Opportunities for the participant to engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS;

(v) Cultural and religious considerations;

- (vi) Strategies for solving disagreement between the participant and providers;
- (vii) A reflection of the choices made by the participant regarding services and supports the participant receives and from whom;
- (viii) What is important to the participant and for the participant;
- (ix) How the delivery of services will be provided in a manner reflecting personal preferences and ensuring health and welfare;
- (x) The participant's strengths and preferences;
- (xi) Any rights or freedoms that are restricted, including why the restriction is imposed, how the restriction is imposed, and the plan to restore the right to fullest extent possible.
- (xii) Both clinical and support needs;
- (xiii) Desired outcomes of the participant;
- (xiv) Risk factors and plans to minimize them;
- (xv) Individualized backup plans and strategies when needed;
- (xvi) Individuals important in supporting the participant, such as friends, family, professionals, specific staff or providers;
- (xvii) Learning objectives for habilitation services that address the training activities, training methods, and the measurement used to gauge learning.
- (xviii) Schedules to document each direct care service provided. The purpose of the schedule shall be to provide information about the services and supports needed throughout a participant's day and justify the rates for services. Schedules shall be personalized and shall:
 - (A) Reflect the purpose of the services.
 - (B) Reflect recommendations from therapists, physicians, psychologists, and other professionals.
 - (C) Reflect the participant's desires and goals.
 - (D) Include all information required by this chapter in Section 8, Documentation standards.
- (xix) Informed consent of the participant in writing; and
- (xx) Signatures of all providers listed in the plan of care;

(c) The plan of care shall be reviewed at least semi-annually, when the participant's circumstances or needs change significantly, and at the request of the participant. The plan shall be revised upon reassessment of functional need, as needs arise, and every twelve (12) months for a new plan year.

(d) The individual plan of care must be written in plain language that is understandable to the participant, legal guardian(s), and persons serving the participant.

Section 11. Rate Reimbursement Requirements.

(a) Providers shall be reimbursed for services through the Department's cost based reimbursement system.

(b) Rates paid to providers for waiver services must be less than or equal to the usual and customary rates for similar services in the community.

(i) The Department shall consult with waiver service providers, developmental disability waiver program participants and their families to gather information about reimbursement rates prior to calculating the new reimbursement rates.

(ii) The Department shall follow a competitive bidding process to procure the services of an expert in the development of cost-based waiver program payments to assist with the development of new reimbursement rates for waiver providers.

(iii) The Department shall receive approval from the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services prior to the implementation of a new, or modified, reimbursement rate setting methodology.

(c) Upon request, providers of home and community based waiver program services for persons with developmental disabilities, or acquired brain injury, shall submit the following information to the Division:

(i) Cost data;

(ii) Claims data; and

(iii) Participant needs assessment data.

(iv) Providers shall also participate in reasonable audits of the data submitted.

Section 12. Service and setting requirements for social security recipients.

(a) One month prior to the provider's scheduled recertification date each year, all residential service providers shall provide the Division with the following information:

(i) The license or certification category of each residential facility serving four (4) or more participants;

- (ii) All services provided in each facility identified;
- (iii) The maximum number of participants that may be served in the facility; and
- (iv) How each facility provides home-like character where participants reside.

(b) This provision does not apply to a participant's private residence or other non-facility community living arrangements.

Section 13. Standards for Provider Facilities.

(a) All certified waiver providers that provide direct care services to participants in a facility they own or lease must meet all applicable federal and state, city, county, and tribal health and safety code requirements. A facility includes the provider's home, if services are provided in that setting.

(b) All certified waiver provider facilities shall provide services that are home and community-based in nature, which means the setting:

(i) Supports full access to the greater community to the same degree as individuals not receiving Medicaid HCBS.

(ii) Is selected by the individual from options including non-disability specific settings.

(iii) Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.

(iv) Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices including daily activities, physical environment, and with whom to interact.

(v) Facilitates individual choice regarding services and supports, and who provides them.

(c) Settings that are not considered home and community-based include, but are not limited to:

(i) A non-residential facility located in an area that does not have established sidewalks, walking paths, or access to the broader community and other businesses where the participants may visit within a safe and reasonable walking distance from the facility.

(ii) Any other facility with characteristics that appear to be institutional in nature, adjacent to an institution, or have the effect of isolating the participants from the community.

(iii) A setting designed to provide multiple services on-site to participants, including housing, day services, medical, behavioral, and therapeutic services, or social and recreational activities.

(iv) Provider facilities certified prior to the effective date of this rule may continue to provide services in settings that do not meet this requirement, but must begin transitioning towards community-based settings in accordance with a state transition plan approved by CMS pursuant to federal law.

(d) Provider facility inspections.

(i) For each location where services are provided, except the participant's own home, the provider or the participant's self-directed employee shall receive an external facility inspection at least once every twenty-four (24) months. The Division may require more frequent inspections if the Division suspects that the provider or employee's facility would not pass the inspection.

(ii) The external facility inspection must be completed by:

(A) A fire marshal or designee,

(B) A certified or licensed home or building inspector, or

(C) Other appropriate authority prior approved by the Division prior to the inspection.

(iii) External facility inspections required by this section must include verification that:

(A) All areas are free of fire and safety hazards, including, but not limited to, all living and service areas, as well as the garage, attic, and basement areas.

(B) The facility is free of any other significant health or safety concerns, including structural concerns, wiring problems, plumbing problems and/or any major system concerns.

(iv) Facility inspections must include a written report that describes the items checked and recommendations to address areas of deficiencies.

(v) If the external facility inspection identifies deficiencies, the provider shall submit a written corrective action plan for any deficiencies identified by the inspector and a complete copy of the inspection to the Division within thirty (30) calendar days.

(A) The corrective action plan should address all identified deficiencies.

(B) The Division may request additional corrective actions based on the inspector's report.

(C) No services shall be provided in a facility that does not pass inspection until all deficiencies have been corrected. The Division may also inspect the service location prior to services being rendered.

(vi) If a provider facility is renovated, a new facility inspection must be completed and reviewed by the Division before participants can occupy the area. Renovations that require a new inspection include structural additions, significant remodeling in the facility, or any other project that requires a building permit.

(vii) Providers or self-directed employees that are not required to have a home or facility inspection shall sign a form designated by the Division to verify they are not providing services in any provider-owned or leased facility.

(viii) Providers and employees may not provide services in a facility that is owned or leased by the provider or an employee, which has not had an inspection completed. The Division may sanction or decertify any provider or self-directed employee when they are subsequently found to be providing services in a facility owned, or leased, by the provider or employee, which has not previously passed inspection.

(e) Self-Inspections. A provider or self-directed employee providing services in a facility they own or lease shall complete an annual internal inspection of the facility to verify that the provider is in compliance with this section.

(f) Other service standards.

(i) A participant must be able to have visitors at any time;

(ii) The setting must be physically accessible to the participant;

(iii) In residential service and day service facilities, the provider shall ensure participants have access to food at all times, and provide nutritious meals and snacks. Providers may not require a regimented meal schedule except where individually prescribed, in writing, by a physician.

(iv) Food, whether raw or prepared, if removed from the container or package in which it was originally packaged, must be stored in clean, covered, dated, and labeled containers.

(v) All food must be served and displayed in a clean and sanitary manner.

(vi) Floors and floor coverings must be maintained in good repair and may not be visibly soiled, malodorous, or damaged.

(vii) The walls, wall coverings, and ceilings must be maintained in good repair and may not be visibly soiled or damaged.

(viii) All doors, windows, and other exits to the outside must be effectively protected against the entrance of insects and rodents and shall be maintained in good repair.

(ix) All windows must be free of cracks or breaks.

(x) All restrooms must be provided with trash receptacles, towels, hand cleansers, and toilet tissue at all times.

- (xi) Toilet facilities must be kept clean and sanitary, and maintained in good repair.
- (xii) The overall condition of the home or facility must be maintained in a clean, uncluttered, sanitary, and healthful manner that does not impede mobility or jeopardize a participant's health or safety and allows physical access.
- (xiii) The use of video monitors in participant bedrooms or bathrooms is strictly prohibited.
- (xiv) A provider facility with a private water supply shall have a bacterial test conducted every three (3) years, and the written results shall be submitted to the Division within thirty (30) days of receiving test results.
- (xv) Providers shall ensure that all participants residing in a provider owned or leased facility have:
 - (A) A lease or residency agreement for the bedroom and location in which they are agreeing to reside. The lease or agreement must be signed by the participant or legally authorized representative (if applicable), and the provider. The lease or agreement must allow the same responsibilities and protections from eviction as all tenants under landlord tenant law of the state, county, city where the facility is located. At no time may a participant be asked to leave their residence on a regular basis to accommodate the provider;
 - (B) Freedom and support to control the participant's schedules and activities;
 - (C) Freedom to furnish and decorate the participant's sleeping and living units within the lease or other agreement;
 - (D) A private bedroom with no more than one (1) person to a bedroom unless otherwise approved by the Division. An exception may be allowed if it is identified in participants plans of care and one of the following criteria is met:
 - (I) The participant is under two (2) years of age;
 - (II) The services provided are episodic;
 - (III) The arrangement is determined medically necessary;
 - (IV) The participants are related and request to share a bedroom;
 - (E) An individual bed, unless the participants are legally related or joint sleeping accommodations are specifically requested by the participant, and specified in the approved plan of care;
 - (F) Access to appropriate egress and a lockable entrance, which can be unlocked by the participant. No devices may be used that prohibit a participant's entry or exit from a room;

(G) A secure place for personal belongings, which the participant may freely access;

(H) A key to both the housing unit, the participant's bedroom, and any form of locked storage where the participant's personal belongings are kept; and

(I) Other appropriate sleeping quarters as necessary to meet health and safety needs for an emergency placement into a provider home, as long as the sleeping area allows for personal privacy and immediate egress.

(I) Emergency placement shall be limited to one week unless otherwise approved by the Division.

(II) Following emergency placement, the participant must be permitted to transfer to permanent housing. If the provider is no longer able to serve the participant in permanent housing, the case manager will present the participant with options to transition to other certified providers.

(xvi) The provider may be required to provide written verification of their organization's ability to provide support and supervision to children under the age of twelve (12) or other participants requiring support and supervision who are in the care and responsibility of the provider. This may include, but is not limited to, licensure by the Department of Family Services or other appropriate state agency.

(xvii) Each provider shall identify, in writing, the potential conflicts of interest among employees, other service providers on the participant's plan, relatives to participants, or any legally authorized representative(s), and address how a conflict of interest shall be mitigated. The provider shall share this information with any potential participants, and legally authorized representative(s), before they are chosen to provide services.

(xviii) Any provider transporting participants shall comply with all applicable federal, state, county, and city laws and requirements, including but not limited to, vehicle and driver licensing and insurance, and shall:

(A) Maintain vehicles in good repair;

(B) Keep current emergency information on each participant in the vehicle or demonstrate how emergency information is quickly accessible each time a participant is transported. If emergency information is kept in the vehicle, the provider shall develop and implement policies to protect the confidentiality and security of participant's health information;

(C) Keep and replenish first aid supplies in the vehicle; and

(D) Conduct regular self-inspections or have the vehicle inspected by a mechanic to ensure that the vehicle is operational, safe, and in good repair.

(xix) Each provider certified to provide employment services, including community integrated employment and group community integrated employment services, shall ensure that:

(A) The participant is involved in making informed employment related decisions.

(B) The participant is linked to services and community resources that enable them to achieve their employment objectives.

(C) The participant is given information on local job opportunities.

(D) The participant's satisfaction with employment services is assessed on a regular basis.

(xx) Any modification to a participant's right to food, non-regimented meal schedule, visitors, communication, privacy or other standard in this Section may only be restricted as documented in written protocols in an approved plan of care with the restriction being time-limited and following the requirements listed in Sections 4 and 18 of this Chapter.

Section 14. Background Check Requirements.

(a) All persons providing waiver services including: managers, supervisors, direct care staff, participant employees hired through self-direction, and any other person who may have unsupervised access to participants or to a participant's residence, shall complete and pass a background screening as referenced in this section. Persons who do not successfully pass a background screening may not supervise, provide, bill for waiver services, or otherwise have unsupervised access to participants or to a participant's residence on behalf of a provider.

(b) Certified providers, their employees, and all legal entities supervising, providing, or billing for waiver services shall also pass and maintain documentation of successful Department of Family Services Central Registry screening and an Office of Inspector General Exclusion Database screening. Entities that do not successfully pass these screenings shall be denied certification or terminated. Screenings must be maintained in the corporate name of the organization or entity and any trade name(s) used in this State.

(c) Background screenings are valid for sixty (60) months and must be renewed prior to their expiration. Any person or entity that subsequently fails to pass a renewed background screening may not supervise, provide, or bill for waiver services following a failed background screening.

(d) Any provider or participant who employs an individual or entity to supervise, provide, or bill for waiver services who has not completed all required background checks may be subject to sanctions under these rules.

(e) Providers and self-direction employees must show evidence of current background screenings for all required persons as part of the provider or employee's recertification.

(f) A successful background screening shall include:

(i) A Wyoming Department of Family Services Central Registry Screening, which shows that the individual is not listed on the Central Registry.

(ii) A United States Department of Health and Human Services, Office of Inspector General's Exclusions Database search result, which shows that the individual or entity is not currently excluded.

(iii) An state and national fingerprinted criminal history record check which shows that the individual has not been convicted, plead guilty to, and does not have a pending deferred prosecution for:

(A) A felony;

(B) A misdemeanor crime against morals, decency, or family;

(C) A misdemeanor crime against a person, including child or vulnerable adult;

(D) A misdemeanor crime involving violence, rape, sexual assault, or homicide;

(E) A misdemeanor crime relating to fraud, forgery, or identity theft; or

(F) A driving under the influence of alcohol, or driving while intoxicated, or related offense during the last three (3) years, if the individual may be driving with a participant in the vehicle.

(g) Individuals no disqualifying criminal convictions occurring in the most recent five (5) years or more may ask the Division to review and waive of requirements in subsection (f)(iii) for convictions occurring five (5) years ago or more.

(h) No person may provide waiver services, or have unsupervised access to a waiver participant ages eighteen (18) or older, unless the Department of Family Services and Office of Inspector General screenings come back with no findings and the state and national criminal history screenings are in process.

(i) An individual provider staff may provide services to a participant ages 18 or older following a successful Department of Family Services and Office of Inspector General screening while the state and national criminal history screenings are pending.

(j) Persons without successfully passing the criminal history screenings listed in subsection (f) may not be left unsupervised in the vicinity of any participant.

(k) Staff may not provide any services to participants ages seventeen (17) or younger until all successful background screenings listed in subsection (f) have come back with no findings.

(l) Each individual eighteen (18) years of age or older who is living in a provider's home where services are provided, or staying in the home for a period longer than one (1) month, shall pass a background check as listed in this Section.

(i) Waiver participants receiving services in this location are not required to complete a background screening.

(ii) Providers may not employ or permit individuals registered as a sexual offender to stay in the home.

(m) If a criminal history screening does not include a disposition of a charge or if an individual is charged with an offense listed in subsection (f)(iii) the individual may not have any unsupervised access or provide billable services to participants until he or she passes a background check pursuant to subsection (f), which must be obtained at the provider's expense.

(n) If a provider or employee appears on a substantiated DFS Central Registry or on an OIG Exclusion screening, then the provider or employer shall be suspended immediately from the provision of services for any of the waivers until resolution of the charges, which means the person may not supervise, provide any direct care, have any unsupervised access, or provide billable services to participants until the results of a passed background check are submitted to the Division.

(o) Volunteers and individuals under the age of eighteen (18) shall be under the direct supervision of an adult, who have passed a background check. Individuals convicted of a sexual offense are not permitted as volunteers.

(p) Any individual that has had a successful background screening may transfer their background check confirmation form from one provider entity to another as long as they have submitted a signed and notarized release to the receiving provider entity and the background check confirmation form is no more than sixty (60) months old. The background check confirmation form belongs to the individual that was screened and can only be used for the purposes listed in the original request. Each time an individual terminates employment and goes to work for another provider where a gap in employment exists of more than seven (7) calendar days, a full background check must be completed for the new employer.

(q) Only one (1) provider or employee may be listed on the DFS central release forms, and criminal history records requests. The background screening notification may not be altered in any manner, including the crossing out of names or use of whiteout. If altered, the release forms shall be determined as null and voided.

(r) The Division may request a background screening at the Division's expense as part of an investigation.

Section 15. Provider Training Standards.

(a) In addition to the other training standards in this Chapter and the Wyoming Medicaid rules, providers shall ensure that employees, including management staff responsible for providing supports and services to participants, are qualified to provide waiver services by

receiving training in the areas specified in this Section prior to working unsupervised with participants in services.

(b) Staff responsible for providing direct services shall demonstrate the competence to support participants as part of a required and on-going training program. The provider shall ensure staff receive training and demonstrate competencies under the guidance of an already trained and proficient staff member prior to working alone with participants.

(c) The provider shall document in the employee's personnel record that they are qualified to provide waiver services through evidence of completed trainings, including when it was completed, who provided the training, and how the employee demonstrated competency. The provider shall ensure that training is performed by persons with expertise in the topic area, who are qualified by education, training, or experience and to maintain complete verification of such.

(d) All persons qualified to provide waiver services shall complete training in the following areas within one month of an employee's hire or provider certification date. Providers may choose to develop their own training modules for employees or use Division modules, as long as the provider covers the key elements of each topic specified in the Division module. General training topics include:

(i) Participant choice;

(ii) The rights of participants in accordance with state and federal laws, and any rights restrictions for each participant with whom a person works. Providers of only environmental modification services, specialized equipment, or homemaker services are exempt from this training requirement;

(iii) Confidentiality;

(iv) Dignity and respectful interactions with participants;

(v) Preventing, recognizing and reporting abuse, neglect, intimidation, exploitation, and all other categories of the Division's Notification of Incident form;

(vi) Responding to injury, illness, and emergencies;

(vii) Billing and documentation of services;

(viii) Releases of information;

(ix) Grievance and complaint procedures for participants, guardians, provider employees, and community members; and

(x) Implementing and documenting participant objectives and progress on objectives.

(e) To verify each provider, provider staff, and self-directed employee meets the qualification standards, evidence of a completed training summary or test of each of training topic must be retained in the employer's files.

(f) One representative from the provider agency shall receive training on the provider recertification process.

(g) Any person who provides a service for which a license, certification, registration, or other credential is required shall hold the current license, certification, registration, or credential in accordance with applicable state laws. The provider shall maintain documentation of the staff credentials.

(h) Participant specific training.

(i) A provider of waiver services must be trained in any specific assistive technology devices, disabilities, diagnoses, or medical or risk conditions as necessary for the participants served by the provider. This training shall be unique to and meet the needs of the participant.

(ii) The participant's plan of care team shall identify an appropriate person to provide participant specific training to provider staff in accordance with this section.

(iii) Each provider, provider staff, and self-directed employee shall receive participant specific training prior to the plan of care start date and whenever there are changes to the individualized plan of care.

(iv) All case managers shall ensure providers and provider employees on the plan receive plan of care training from the designated person agreed upon by the team. The case manager and the participant or any legally authorized representative(s) may request verification of the provider's participant specific training.

(i) Documentation of participant specific training and general training must include:

(i) The date of the training.

(ii) The name, signature, and title of the trainer.

(iii) The name and signature of the person receiving the training.

(iv) A detailed agenda of the training topic(s), including the method of training.

Section 16. Medical Management System Standards.

(a) A provider who is responsible for the health, medical, or medication needs of a participant shall implement a medical management system to ensure a participant's health and medical needs are met.

(b) The designated provider as identified by the participant's team shall take reasonable steps to assist and support participants in obtaining health services consistent with his or her needs, unless otherwise assigned in the individualized plan of care to a non-waiver provider.

(i) Participant health services include medication assistance and monitoring, medical services, dental services, nutritional services, health monitoring and supervision, and assistance with personal care, personal health care and education, exercise, or therapies.

(ii) Services also include arranging for and assisting the participant as needed to obtain evaluations and services, such as physical exams, dental services, psychological services, physical and occupational therapy, speech therapy, audiological services, vision services, nutrition therapy, and other related evaluations and services.

(c) Unless otherwise directed by the participant's physician, nurse practitioner, or physician assistant, each participant shall receive the following evaluations:

(i) A medical evaluation every twelve (12) months;

(ii) A dental cleaning every twelve (12) months; and

(iii) An eye exam every three (3) years or more frequently if required by a medical professional.

(d) The provider's medical management system must include written protocols for administration of medication, treatments and therapies as appropriate for each participant. The system must also include a process for maintaining health-related records on each participant to document the provision of services and the participant's response to services. The records must include:

(i) Any health related assessments;

(ii) Documentation of an illness, injury, and other health concerns of care, treatment, and medication administration;

(iii) Documentation of provision of health-related services, including observations of the participant's response, progress, or lack of response or progress in provision of service;

(iv) Current physician orders for medication, treatments, and therapies;

(v) Records of visits to the physician or other health care professionals and their recommendations and any other consultation or therapy provided; and

(vi) Information related to hospitalization, nursing facility stays, or other types of health care providers.

(e) Any provider of direct care services shall ensure that the health status and physical conditions are observed, reported, and responded to in a timely and appropriate manner as needed. For a participant whose responsibility for obtaining health services has been assigned to

someone other than the provider, the assigned provider shall observe, report, and respond to the participant's health service needs to ensure needs can be appropriately met.

(f) Any provider of direct care services shall ensure a participant receives care, treatment, and medications in accordance with orders from a medical practitioner. Responsibilities of each provider on a participant's plan must be discussed and documented during the participant's plan of care meeting. Recommendations from other health care professionals must be reviewed by the participant's plan of care team and incorporated into the plan of care as determined by the team.

(g) Any provider of direct care services shall assist participants with the utilization of assistive and adaptive devices as needed and as identified on the plan of care.

(h) Any provider of direct care services shall have policies and procedures to assist participants with medications according to the Division's Medication Assistance policy using staff with current and valid certification through the Division's Medication Assistance curriculum and standards.

(i) A provider shall obtain written consent from a participant or guardian to assist the participant with medications. The consent shall be documented on a form designated by the Division and obtained annually.

(ii) The participant's individualized plan of care shall identify the level and type of medication assistance that must be provided by specific providers on the plan.

Section 17. Positive Behavior Supports.

(a) Participants shall receive treatment and habilitation services designed to maximize the potential of the participant and provided in the setting that is least restrictive of the participant's personal liberty.

(b) Participants shall have access to positive behavioral supports as behavioral interventions from providers prior to the use of any restrictive intervention.

(c) Challenging behaviors may include actions by the participant that constitute a threat to the person's immediate health and safety, the health and safety of others in the environment, a persistent pattern of behaviors that inhibit the participant's functioning in public places and integration within the community, or uncontrolled symptoms of a physical or mental condition.

(d) A participant with a challenging behavior identified by the team shall have a current functional behavioral analysis conducted to learn what the person is trying to communicate through the behavior(s), the function or possible purpose for the behavior(s), to explore antecedents and contributing factors to behaviors, and to review and describe potentially positive behavioral supports and interventions in order to develop a positive behavior support plan.

(i) The functional behavioral analysis shall include data compiled regarding all behaviors exhibited and be utilized to develop the positive behavior support plan used by the provider during the provision of waiver services.

(ii) A person chosen by the participant shall write the functional behavior analysis, which shall include input from the team, participant, and any legally authorized representative(s).

(e) A positive behavior support plan, based upon a current functional behavioral analysis, must be developed for a participant in order for employees working with the person to understand and recognize the communication and behaviors exhibited by the person. The positive behavior support plan must describe agreed upon supports to assist the participant using proven support techniques and non-restrictive interventions. A positive behavior support plan must include the components included on the template provided on the Department's website. At a minimum, a positive behavior support plan must:

(i) Maintain the dignity, respect, and values of the participant.

(ii) Use a person-centered approach with the participant involved in the development of the plan on a level appropriate for that person.

(iii) Prevent the use of restrictive interventions or restraints. If restraints are used then the positive behavior support plan has failed, and must be reviewed to possibly add or modify the service environment or behavioral interventions.

(iv) Be specific and easily understood, so direct care employees can implement it appropriately and consistently.

(v) Be approved by verification of a signature by the participant or any legally authorized representative(s) through informed consent. As part of the informed consent process, education must be given by the provider to the participant and any legally authorized representative(s) regarding positive behavior supports that may be used and the risks and benefits of any supplemental plan for the use of a restrictive intervention, prescribed psychoactive medication, or restraint if the positive behavior support plan fails.

(vi) Define the antecedents and the targeted behavior(s) that need to be replaced or reduced.

(vii) List positive behavioral supports that assist the participant in replacing targeted or challenging behaviors with appropriate replacement behaviors.

(viii) Provide protocols for providers and provider employees to recognize emerging targeted behaviors, and determine the appropriate interventions to implement positive behavioral supports

(ix) Provide protocols for employees to respond when targeted behaviors take place; protocols must focus on positive interventions that are the least restrictive and the most effective.

(x) Reviewed quarterly by the provider(s) to assess the effectiveness of the plan, or more frequently if needed.

(xi) Include specific guidelines for tracking and analyzing the antecedents related to the occurrence of a targeted behavior, the actual behavior(s) displayed, and the results of positive behavioral interventions.

(f) A provider employee implementing a positive behavior support plan shall receive competency-based training on the positive behavior support plan, and on specific positive de-escalation techniques and interventions before they begin working with the participant.

(g) The providers shall maintain and analyze trend data relative to the occurrences of behaviors, antecedents, and the interventions, restrictions, or restraints used. When appropriate, the provider shall change approaches, modify the plan when it is no longer effective, or eliminate the plan when it is no longer needed.

Section 18. Restrictive Intervention and Restraint Standards.

(a) When the use of positive behavior supports is not effective in modifying or changing a participant's challenging behavior, the participant's plan of care team may implement a restrictive intervention protocol to supplement the positive behavior support plan, subject to the provisions of this section. The provider shall have and implement policies and procedures governing its use of restrictive interventions, which complies with state and federal statutes, rules, regulations, and Division policy.

(b) The plan of care team shall review the participant's plan thoroughly to ensure the plan of care is not so restrictive that it repeatedly provokes behaviors that lead to restraints.

(c) A provider, who uses any restrictive interventions, shall provide leadership and an organizational culture for employees and participants focused on reducing and eliminating the use of restraints.

(d) The use of chemical or mechanical restraints on children is prohibited.

(e) Use of restrictive interventions must be chosen and deemed appropriate and effective by the entire plan of care team, confirmed with a signature from the participant, legally authorized representative and all providers involved.

(f) Providers may only use restrictive interventions when the risk of injury without intervention is greater than the risk associated with the restrictive intervention.

(g) A restrictive intervention protocol must include:

(i) The reasons for the restriction(s), including the legal document, court order, or guardianship papers, or medical order, that allow for a restriction to be imposed.

(ii) A clear description of the modification or restriction that is directly proportionate to the specific assessed need.

(iii) The conditions that must exist and how the restriction(s) may be imposed.

- (iv) A reasonable length of time regarding when the right may be restored.
- (v) Information on temporarily lifting the restriction when appropriate, for example during times of personal crisis.
- (vi) Established time limits and designated staff for periodic reviews to determine if the restriction is still necessary or can be terminated.
- (h) Restrictive interventions may only be imposed by an individual trained and certified to impose the restriction.
- (i) If restraints are used as a form of restrictive intervention, the provider shall adhere to all state and federal restraint rules. The provider shall maintain certification and provide ongoing training for employees in de-escalation techniques, crisis prevention and intervention, and proper restraint usage through a nationally recognized certifying entity, such as Crisis Prevention Intervention (CPI), MANDT, Therapeutic Options, or a similar entity.
- (j) All provider staff trained to use restrictive interventions shall also receive training in:
 - (i) The needs and behaviors of the population served;
 - (ii) Relationship building;
 - (iii) Alternatives to restrictive interventions;
 - (iv) Avoiding power struggles;
 - (v) Thresholds for restraint and seclusion;
 - (vi) Monitoring signs of distress and obtaining medical assistance;
 - (vii) Legal issues related to restrictive interventions;
 - (viii) Position related asphyxia;
 - (ix) Escape and evasion techniques;
 - (x) Time limits;
 - (xi) The process for obtaining approval for continued restraints;
 - (xii) Procedures to address problematic restraints;
 - (xiii) Documentation;
 - (xiv) Any participant specific medical concerns and processes;
 - (xv) Follow-up with staff and the participant; and

(xvi) Investigation of injuries and complaints.

(k) An accredited provider serving more than five (5) participants with restraints or restrictive interventions in their plans are required to have a supervisor successfully complete positive behavior support curriculum through a nationally recognized positive behavior support curriculum approved by the Division. An additional supervisor shall be certified for every ten (10) additional participants with restraints or restrictive interventions in their plan.

(l) Restrictive interventions may only be used in emergency circumstances to ensure the immediate physical safety of the participant, a provider staff member, or other persons, and when less restrictive positive behavior supports have been determined to be ineffective. Restrictive interventions may include:

(i) A “time out,” which is a time limited behavior management technique which involves the separation of a resident from his or her peers, in a non-locked setting, for the purpose of calming. Any isolation of the participant that does not meet this definition shall be deemed seclusion, which is prohibited and shall result in recovery of funds and additional sanctions against the provider.

(ii) A chemical restraint, which is a psychoactive medication administered as a restrictive intervention. A chemical restraint may not be used unless ordered by a treating physician chosen by the participant or any legally authorized representative(s), and administered by person licensed to administer the medication. Standing orders for chemical restraints are prohibited except where deemed necessary to prevent extreme reoccurring behavior by a participant’s plan of care team and limited to one month.

(iii) A mechanical restraint, which includes any device attached or adjacent to a participant’s body that he or she cannot easily move or remove, restricts freedom of movement or normal access to the body. Mechanical restraints may only be used under the direct supervision of a physician for the purpose of medical treatment procedures when compliance is deemed necessary to protect the health of the participant.

(iv) A physical restraint.

(A) Physical restraint includes:

(I) The application of physical force or physical presence without the use of any device for the purposes of manually holding all or part of a person’s body in a way that restricts the person’s free movement,

(II) The use of any approved physical maneuvers, such as a physical escort, team positions, or other holds to move a participant to another place or position, or

(III) Any other physical or manual technique intended to interrupt or stop a behavior from occurring, except:

(1) Briefly holding a participant without undue force in order to calm or comfort him or her, or

(2) Holding a participant's hand to safely escort him or her from one area to another due to a potentially dangerous environmental concern that is not a result of the participant's behavior.

(B) The application of physical restraint must be approved by the participant's attending medical physician, and used in accordance with a Division approved crisis intervention plan.

(v) A Community Access Restriction: Community access may not be restricted as a consequence due to non-compliance with attending a service or not completing a goal or training activity. If the community access restriction is imposed, the protocol must also include:

(A) Specific target behaviors that must be present in order for a restriction to the community to be imposed, a description of the risk to the community, and the specific measureable and observable criteria for restoring access to the community.

(B) Community access restrictions may not be imposed by a person who is also designated to reassess the participant throughout the day to ensure health and safety needs are being met. The reassessment must include measureable progress made on restoring access to the community.

(C) Opportunities for the participant to reduce the length of time of restriction.

(D) The provider may not restrict community access for any other participant for which the restriction is not directly imposed.

(E) The provider may not charge a participant for services missed as a result of a community access restriction.

(m) A provider using restrictive interventions shall:

(i) Maintain internal documentation to track and analyze: each use of a restrictive intervention, its antecedents, reason(s) for the restrictive intervention, the participant's reaction to the restrictive intervention, and actions that may make future restrictive interventions unnecessary;

(ii) Implement additional supports with the participant in an effort to minimize restrictive interventions;

(iii) Use appropriate de-escalation techniques to redirect or mitigate a behavior before restrictive interventions occur;

(iv) Address and correct staff using any incorrect or inconsistent support or intervention;

(v) Hold a debriefing meeting with the participant and guardian as soon as practicable after an incident to discuss the use of the restriction. Guardians shall be part of the participant's debrief discussion either by phone or in person;

(vi) Provide case managers with a copy of the provider's internal tracking form within twenty-four (24) hours of the event;

(vii) Send a copy of the internal tracking form to the guardian within five (5) business days;

(viii) When warranted, and at least quarterly, ask the case manager to reconvene the participant's plan of care team to make plans for reducing the number of restrictions imposed;

(ix) Submit a critical incident report to the Division for each instance when a restrictive intervention is used;

(x) Regularly collect and review all available data regarding the use of restrictive interventions and work to reduce their frequency and eliminate their occurrence.

(n) The case managers shall follow up on each incident within 48 hours to ensure the participant is safe, uninjured, and to ensure the participant's positive behavior support plan was implemented appropriately. The case manager shall also determine whether the items in this section were completed and report any non-compliance to the Division.

(o) On a quarterly basis, the case manager shall report, using the form and in the manner required by the Division, data received from the provider concerning the number of restrictions imposed on the participant.

(p) Providers may not use seclusion for any purpose. Seclusion is the involuntary confinement of an individual alone in a room or an area from which the individual is physically prevented from having contact with others or leaving, or physically restrain a person back to such a room once he or she leaves during the provision of the waiver services. The use of any type of seclusion shall result in a full recovery of funds paid to the provider for that participant for any day in which the seclusion is used and other sanctions under these rules.

(q) Restrictive interventions may not be used for the following purposes. Violation of this provision may result in immediate sanctions of the provider:

(i) For the convenience of the provider;

(ii) To coerce, discipline, force compliance, or retaliate against a participant;

(iii) As a substitute for a habilitation program or in quantities that interfere with services, treatment, or habilitation;

(iv) Restraint that is contraindicated by the person's medical or psychological condition;

(v) Restraint procedures or devices that obstruct a person's airway or constrict the person's ability to breathe;

(vi) The use of any supine or prone restraint including, but not limited to, restraining a person on the floor, in a bed, in any form of reclined chair, or using any other horizontal flat surface;

(vii) Any use of physical, mechanical, or chemical restraint not provided for in this section.

(r) Any restrictive intervention used, including a restraint, must be time-limited and removed immediately when the participant no longer presents a risk of immediate harm to self or others.

Section 19. Psychoactive Medication Usage Standards.

(a) If a participant is prescribed psychoactive medication as standard treatment, then the provider shall ensure the following:

(i) The participant is diagnosed with a medical condition by a licensed psychiatrist or physician and may benefit from the use of psychoactive medications;

(ii) The medical section of the participant's approved individualized plan of care must:

(A) Describe the behaviors for which the medication is prescribed;

(B) Justify use of the medication(s), including the benefits and potential side effects;

(C) State the length of time considered sufficient to determine if the medication is effective (i.e., treatment trial);

(D) Identify the behavioral criteria to determine whether the medication is effective, such as the changes in behavior, mood, thought, or functioning that may be considered evidence the medication is effective;

(E) Describe the plan to monitor medication side effects; and

(F) Describe the plan to simplify the number and types of medications and to reduce dosages and discontinue medications, unless otherwise contraindicated.

(b) If the attending medical physician prescribes a psychoactive medication PRN that may be used during the provision of waiver services, a PRN protocol for use of the medication must be developed to supplement the positive behavior support plan pursuant to the Sections 17 of this Chapter. In addition the provider shall ensure that:

(i) Prescribed psychoactive medications may only be administered to manage a person's behavior with the approval of the participant or the participant's legally authorized representative(s), and the Division, through the approval of the participant's individualized plan of care or a modification to the individualized plan of care;

(ii) The use of such drugs and medications must be in the best interest of the participant to improve his or her quality of life;

(iii) The use or threat of physical force for the administration of psychoactive medications is not allowed; and

(iv) Documentation of the non-pharmacological interventions which will be used prior to the use of a psychoactive medication PRN.

(c) Psychoactive medication monitoring requires the provider to monitor the participant's response to one or more prescribed medications, to observe the participant for side effects, correct dosage and intervals, and follow other medically approved best practice monitoring methods, in conjunction with orders from the treating physician.

(d) Any participant's medication regimen that includes psychoactive medications, includes any contraindicated medications, or includes other classifications of medications that are intended to have a psychotropic effect may be subject to a polypharmacy referral to Medicaid.

(e) If a scheduled psychoactive medication dosage is missed, it must be reported as a medication error and the prescribing physician must be notified by the provider to take further action.

Section 20. Notification of Incident Process.

(a) A provider shall report the following categories of critical incidents involving waiver participants to the Division, the Department of Family Services, Protection & Advocacy Systems, Inc., the case manager, any legally authorized representative(s), and to law enforcement:

(i) Suspected abuse as defined by W.S. § 35-20-102 or W.S. § 14-3-202.

(ii) Suspected self-abuse.

(iii) Suspected neglect as defined in W.S. § 35-20-102 or W.S. § 14-3-202.

(iv) Suspected self-neglect as defined W.S. § 35-20-102.

(v) Suspected abandonment as defined in W.S. § 35-20-102.

(vi) Suspected exploitation as defined in W.S. § 35-20-102.

(vii) Suspected intimidation as defined by W.S. § 35-20-102.

(viii) Sexual abuse as defined in W.S. § 35-20-102.

(ix) Death.

(b) All providers shall report the following non-critical incidents to the Division, Protection & Advocacy Systems, Inc., the case manager, and any legally authorized representative(s):

(i) Police involvement, such as arrests of participants or the participant's direct care provider, or questioning of participants by law enforcement;

(ii) Any use of restrictive interventions, which includes any use of a restraint;

(iii) Any use of seclusion;

(iv) Any restriction imposed by a provider resulting in a participant's loss of possessions, access to the community, communication to others, or privacy;

(v) Injuries caused by restraints;

(vi) Elopement, which is defined as the unexpected or unauthorized absence of an participant for more than is approved in the participant's plan of care when that person is receiving waiver services, or the unexpected or unauthorized absence of any duration of a participant whose absence constitutes an immediate danger to themselves or others;

(vii) Out of area, an unexpected participant action which may not be intentional and may be due to wandering that is secondary to dementia;

(viii) Medication errors, including:

(A) Wrong medication,

(B) Wrong dosage,

(C) Missed medication,

(D) Wrong participant, and

(E) Wrong route.

(F) Wrong Time, which is any deviation from accepted standard time frame for the medication assistance; and

(ix) Medical or behavioral admission and Emergency Room or Urgent Care visits that are not scheduled medical visits.

(c) If, at any time, a significant risk to a waiver participant's health and safety is found, or a participant's health and safety, the provider shall report the incident in the appropriate category.

(d) Reports must be filed no later than twenty-four (24) hours after the event occurred.

(e) Providers shall maintain internal incident reports for all critical and non-critical incidents identified in this section. Providers shall review internal incident data including the

people involved in the incident, the preceding events, follow up conducted, causes of reoccurring critical incidents, other trends, actions taken to prevent similar incidents from reoccurring, evaluation of actions taken, education and training of personnel, and internal and external reporting requirements.

(f) A provider shall comply with Division, or other agency requests, for additional information relating to the incidents within three (3) business days.

Section 21. Complaint Process.

(a) Accredited Providers. All accredited providers shall adhere to the current accreditation requirements for complaints or grievances.

(b) A provider, who is filing a complaint that he or she believes a participant's health or safety is in jeopardy, shall immediately contact the Division, and other governmental agencies, such as law enforcement or DFS.

(c) Upon receipt of a complaint from any person, the Division shall:

(i) Notify the complainant within ten (10) calendar days in writing that the complaint is received. The notification must address:

(A) Anticipated timeframe for completing complaint investigation.

(B) The authority for taking actions.

(ii) Notify the provider in writing when a complaint is received involving that provider, unless the complaint involves significant health, safety, or rights concerns, which require an unannounced on-site visit. In these cases, the Division shall provide written documentation to the provider at the time of the on-site investigation that a complaint has been received and is being investigated.

(iii) Notify the complainant when the complaint has been investigated and closed.

(iv) Submit a written report to the provider(s) involved in the complaint summarizing the results of the complaint investigation. The report may include findings, recommendations, and timeframes to address the recommendations through a corrective action plan.

(v) A provider's failure to complete a corrective action plan may result in sanctions.

Section 22. Transition Process.

(a) The participant may choose to change any provider at any time and for any reason.

(b) A provider who is terminating services with a participant shall notify that participant in writing at least thirty (30) days prior to ending services, unless the Division approves a shorter transition period in advance. Failure to provide services during this thirty (30) day period shall be considered abandonment of services and may result in decertification of the provider.

(c) When a participant, or any legally authorized representative(s), chooses to change providers, they shall inform the participant's case manager of the decision.

(d) When a transition occurs, the case manager shall:

(i) Notify the Division of the request for change within five (5) business days of request.

(A) If the participant, or any legally authorized representative(s), requests a change of case manager, the Division shall review choice and provider lists with the participant and guardian.

(B) If the participant or legally authorized representative(s) requests a change of a provider other than case manager, the case manager shall review choice and provider lists with the participant or legally authorized representative(s).

(ii) Complete the Transition Checklist as required by the Division,

(iii) Gather and share appropriate information as outlined in the Transition Checklist,

(iv) Schedule individualized plan of care team meetings and notify all current and new providers, the participant, any legally authorized representative(s), and the Division at least two (2) weeks prior to the meeting. Team meetings may be scheduled sooner than two (2) weeks due to an emergency situation. Case managers shall notify the Division of any emergency requiring a faster transition schedule, and

(v) Modify the participant's plan of care.

(A) If a revised individual plan of care is required, the case manager shall complete the revised plan and submit it to the Division at least thirty (30) days before the new provider(s) is scheduled to begin providing services.

(B) If the individualized plan of care only requires minor modification, the case manager shall complete and submit plan of care modifications to the Division at least seven (7) days prior to the scheduled start date of the new services.

(e) All providers on the plan of care shall share pertinent information with the case manager and the individualized plan of care team in a timely manner.

(f) If a provider providing residential services to a participant requires a participant to move to another residential location, the participant shall be given the opportunity to choose from all available options without limitation to that provider's settings.

(i) The participant may choose from other setting options that are appropriate for the participant, which may include a new provider or as supported living.

(ii) The provider shall notify the participant, family, case manager, and any legally authorized representative(s) of the move at least thirty (30) days in advance so the participant can exercise the choice to find a new residence or provider.

Section 23. Notice of Costs to the Participant.

(a) The provider shall develop and implement a system for notification to participants and legal representatives of any associated cost to the participant for a service or item and the terms of payment, which are the responsibility of the participant or the legally authorized representative(s).

(b) Written notice must be given to the participant before initiation of service and before any change. Providers shall allow participants and their legal representative(s) adequate time to review the notice before the participant chooses services from the provider or before the changes are implemented.

(c) A provider's cost notice must specify that participants will not be charged for services or items that are covered through other funding sources. This includes, but is not limited to, items necessary to provide habilitation and transportation related to habilitation. The cost notice must also identify:

(i) Who is responsible for replacement or compensation when participants' personal items are damaged or missing; and

(ii) How participants will be compensated when staff or other participants in service, who do not reside in the location (i.e., respite) utilize the environment and eat food paid for by participants. This excludes any visitors or guests invited by the other participants to socialize in the residence.

Section 24. Participant Funds and Personal Property.

(a) Standards in this Section apply to any provider who takes responsibility for the funds or personal property of a participant, which includes:

(i) Serving as representative payee or conservator.

(ii) Involvement in managing the funds of the participant.

(iii) Receiving benefits or funds on behalf of the participant.

(iv) Temporarily safeguarding funds or personal property for the participant.

(b) The provider shall develop and implement written policies and procedures to identify and detail the system used to protect participant's funds and property. These policies and procedures must be communicated to the participant or legally authorized representative(s), including:

(i) How the participant or any legally authorized representative(s) will give informed consent for the expenditure of funds,

(ii) How the participant or legal representative(s) may access the records of the funds,

(iii) How funds are segregated for accounting and reporting purposes to the participant, guardian, and regulatory agencies, such as Social Security Administration or the Office of Healthcare Financing

(iv) Safeguards used to ensure that funds are used for the designated and appropriate purposes,

(v) If interest is accrued, how interest is credited to the accounts of the participant,

(vi) How services fees are charged for managing funds, and

(vii) How the person's funds or personal property will be replaced or recouped in the event of theft or an unexplainable disappearance at the provider facility or during the provider's provision of services.

(c) Providers may not use or allow participant funds or personal property to be used:

(i) As a reward or punishment;

(ii) As payment for damages unless the plan of care team reviews, on a case by case basis, whether it is appropriate for the participant to make restitution, the rationale is documented, and the participant or legal representative gives written informed consent to make restitution for damages;

(iii) As payment for damages when the damage is the result of lack of appropriate supervision or lack of programmatic intervention;

(iv) To purchase inventory or services for the provider; or

(v) On loan to the provider or the provider's employees.

Section 25. Additional Standards for Providers that Require National Accreditation.

(a) Providers who are certified in any residential service, supported living, community integration, adult day services, day habilitation, prevocational, any supported employment service, and are on plans of care for three (3) or more participants shall receive national accreditation if the provider's waiver income equals or exceeds \$125,000 per calendar year.

(i) Providers shall obtain accreditation in the area applicable to each service within eighteen (18) months qualifying under this provision.

(ii) If multiple providers own or lease the same facility to provide waiver services prior to the effective date of this rule, the accreditation requirement pertains to the total number

of participants being served in the facility. In such case, each provider shall become nationally accredited.

(b) Provider accreditation options include Commission on Quality and Leadership (CQL), CARF, or another nationally recognized accreditation entity approved by the Division. Regardless of the accreditation attained, all references to accredited providers in this rule apply to the provider.

(c) A provider shall maintain accreditation as long as they provide qualifying services to three (3) or more participants for one of these services.

(i) The Division shall decertify a provider who fails to obtain or maintain accreditation.

(ii) If a provider fails to obtain or maintain accreditation, a transition plan must be implemented for each participant who is leaving the provider's services.

(A) Each waiver participant shall be relocated to a different provider within ninety (90) days of the date the Division receives confirmation from that the provider did not receive accreditation. If a provider fails to obtain or maintain accreditation, the Division shall complete an immediate site survey and onsite assessment.

(B) The provider's decertification date shall begin ninety (90) days from the date of written notice from the accrediting entity that the provider did not receive accreditation.

(d) An accredited provider shall establish a human rights committee that meets no less than semi-annually. The accredited provider's human rights committee shall review any situation requiring the use of psychotropic medication as outlined in Section 19, any restrictive intervention identified in Section 18, and any situation where violation of a participant's rights has or may have occurred.

(i) The review must include obtaining additional information and gathering input from the affected participant and his/her legally authorized representative(s), if applicable, to make recommendations to the provider.

(ii) The human rights committee shall document its case reviews, findings, recommendations, and other activities.

(iii) Membership of the human rights committee shall include, at a minimum, a representative from the provider organization, a person with a developmental disability, a family member or legally authorized representative(s) of a person with a developmental disability, and a current licensed medical professional who is a registered nurse, advance practice nurse, physician's assistant, or medical doctor.

(A) All members shall be free from conflicts of interest. To this end, any person responsible for approving the participant's services and any staff who provides direct services to the participant cannot participate as decision makers at any time that such participant is before the human rights committee.

(B) The human rights committee shall maintain the confidentiality of information related to the participants discussed.

(C) At least half of the committee's members shall be participants, family, or other interested persons who are not the provider's board members, managers, supervisors, or staff.

(D) The affected participant and the participant's legally authorized representative(s) shall be permitted to participate in the meeting when the case is discussed.

(E) Minutes from the human rights committee must be made available to the Division upon request.

Section 26. Mortality Review Committee.

(a) The Division shall maintain a Mortality Review Committee to review deaths of participants receiving waiver services.

(b) Providers shall provide information requested by the Mortality Review Committee. This may including, but is not limited to:

(i) Copies of documentation of services.

(ii) Copies of incident reports.

(iii) Copies of any health related records, including assessments, and results of physicians' office visits and hospital visit.

(c) The Committee may make provider specific recommendations or systemic recommendations.

Section 27. Initial Provider Certification.

(a) An individual or entity may apply to become a provider by completing the Division's initial provider certification packet and all required trainings. The applicant shall supply evidence that the applicant meets the qualifications for each service that the applicant is seeking certification to provide pursuant to waiver services.

(b) After the effective date of this rule, the Division will only certify one provider per physical location.

(c) The Division may not certify any person or entity as a waiver provider if:

(i) The person or entity has an open or pending corrective action plan with the Division,

(ii) The person or entity has any open cases with the Medicaid Fraud Control Unit.

(d) The Division may refuse to certify an officer, administrator, or board member, which was sanctioned by the Division. This refusal shall apply for a period of two (2) years from the date the provider was sanctioned. The Division may also refuse to certify such person related to his or her involvement in any open or pending corrective action plan, or Medicaid Fraud Control Unit case after the two (2) year period.

(e) Any person, who has been convicted of Medicaid fraud, may not be certified.

(f) The Division may refuse to certify or subsequently decertify a provider applicant who fails to disclose any convictions in a court of law on the Division's provider application or organization's application.

(g) Any falsifications of statements, documents, or any concealment of material fact may result in a denial or certification, decertification, or referral for criminal prosecution.

(h) If the Division receives information that the provider no longer meets the qualifications for each service that the provider is certified for, the Division will immediately send notice to the provider regarding this missing qualification and the applicable sanction. If the missing qualification is not gained within the timeframe given by the Division in the notice, the provider will be disqualified from providing such waiver service(s).

Section 28. Recertification of Providers.

(a) The Division shall notify all providers that their waiver certification is expiring at least ninety (90) calendar days prior to the certification expiration date. The letter shall detail requirements the provider shall meet to be recertified.

(b) The Division shall initially certify a new provider agency providing any service for one year. The agency must complete a recertification at the end of the first year to continue providing services. After the initial year certification, the Division may certify an agency for up to three (3) years, depending on the service(s) provided.

(i) Annual recertification is required for providers certified in Residential Habilitation, Supported Living, Special Family Habilitation Home, Community Integration, Prevocational, any Supported Employment service, Crisis Intervention, Case management, Support Brokerage, and Adult Day Services. Recertification includes annual inspections of all residential or day service facilities owned, leased, or operated by a provider.

(ii) Recertification for up to two (2) years may be allowed for providers certified in Child Habilitation, Companion services, Transportation, Homemaker, Personal Care, Individual Habilitation Training, and Respite.

(iii) Recertification for up to three (3) years may be allowed for certified providers of Skilled Nursing, Occupational Therapy, Physical Therapy, Speech, Hearing and Language Services, Dietician, Environmental Modifications, Behavioral Support Services, and Specialized Equipment.

(c) An agency, who receives a recommendation that identifies non-compliance with any

rule and regulation pertaining to health, safety, rights or the standards for habilitation service provision may only receive up to a one-year recertification pending corrective action on the area of non-compliance.

(i) An agency, who does not receive a recommendation that identifies non-compliance with rules and regulations pertaining to health, safety, rights or habilitation service standards may receive a two or three-year recertification as specified in subsection (b)(ii) and (iii)

(ii) The Division has the authority to monitor agencies throughout their recertification period through the complaint process, incident reporting process, or internal referral process, if there is indication the agency is not complying with the rules and regulations.

(d) For accredited providers, the Division will conduct a site survey for recertification within a three (3) month range and send notification to the provider 60 days prior to the survey date range.

(e) A provider who requires an on-site visit shall request recertification from the Division at least sixty (60) calendar days prior to their certification expiration date. Providers who do not require an on-site visit shall submit verification that they have met all applicable requirements to the Division at least forty-five (45) calendar days prior to their certification expiration date.

(i) If a provider fails to request recertification or fails to submit the applicable requirements to the Division as described above, the Division shall notify the provider in writing of the expiration of the certification and may grant the provider fifteen (15) calendar days to meet the recertification requirements.

(ii) If the provider does not meet the recertification requirements within fifteen (15) business days after the date of the Division's letter, the Division shall decertify the provider.

(A) The Provider may not apply to become a certified provider for a period of two (2) years from the date the provider was decertified.

(B) The provider shall be notified in writing that their certification has expired by certified mail.

(f) During the on-site visit, the Division shall review provider certification requirements and complete a written report, including a statement of the recommendations that may be required in a recertification, within thirty (30) calendar days.

(i) The Division may approve a certification period for up to the timelines noted in subsection (b) depending on deficiencies noted during the recertification process.

(ii) The Division may approve the certification for a period of less than a one (1) year if deficiencies seriously affecting the health, safety, welfare, rights, or habilitation of a participant are identified, or if the provider has otherwise substantially failed to comply with the rules and standards applicable to the services they are providing.

(iii) The Division may deny the certification.

Section 29. Corrective action plan requirements.

(a) The Division will, to the extent practicable and consistent with the provisions of applicable law, seek the cooperation of providers in obtaining compliance with these standards. The Division may provide technical assistance to providers to help them voluntarily comply with any applicable provision of these rules.

(b) The Division may also attempt to resolve any suspected noncompliance with this chapter through a corrective action plan.

(c) Corrective action plans must address each area of suspected non-compliance to the Division's satisfaction. This includes identifying the suspected noncompliance area, action steps needed to address the area of noncompliance, the responsible people in the organization for each action item, due dates, and dates of completion for each recommendation.

(d) Corrective action plans may also include a requirement for specialized training for the provider organization or individual employees. Specialized training may include, but is not limited to, training on positioning, feeding protocols, positive behavior supports, person-centered planning, or trauma-informed care, due to the participants being served by that provider.

(e) Suspected non-compliance that relates to the immediate health, safety, welfare, or rights of participants, shall be addressed immediately after the situation is discovered. Providers addressing suspected non-compliance under this section shall be given fifteen (15) business days from the date of the report issued by the Division to submit a corrective action plan.

(f) If a corrective action plan is not implemented to address all areas of suspected non-compliance, the Division may impose sanctions as warranted.

(g) The Division shall notify the provider in writing within fifteen (15) business days after receipt of the provider's corrective action plan regarding the approval or disapproval of the plan.

(h) The provider shall complete appropriate follow-up monitoring to assure that the actions identified in their corrective action plan have been completed within the specified time frame(s) and submit a monthly status report to the Division in the form and manner required by the Division until all action items have been satisfactorily completed. If the Division does not receive the monthly status report from the provider, the Division may proceed with the sanctioning process.

(i) The Division may complete follow-up investigations or review additional items during the provider's recertification process to assure the provider has fully implemented and evaluated and that participants remain safe during the corrective action plan implementation.

Section 30. Sanctions.

(a) Sanctions may be imposed in accordance with the provisions of Chapter 16, Medicaid Program Integrity.

(b) The Division may impose sanctions for any violation of these rules.

(c) If the Division revokes a provider's certification or suspends a national provider identification number,

(i) The provider shall submit transition plans to the Division detailing the transition of each participant to other settings within thirty (30) calendar days of the date that the sanction is deemed final.

(ii) The transition plans may not be implemented until approval by the Division.

(iii) The transition plans shall be implemented and participants shall move to different certified providers or receive non-waiver supports and services from persons approved by the participants or any legally authorized representative(s) within ninety (90) calendar days of the date the Division informed the provider of the revocation of certification.

(iv) Transition plans must adhere to the requirements in Section 22 of this Chapter.

Section 31. Relative Providers.

(a) The Division shall allow a participant's relative to become a certified waiver provider and receive reimbursement for services provided to the related participant as specified in subsections (e) and (f).

(b) A relative is defined as a participant's biological or adoptive parent(s), stepparent(s), sibling, aunt, uncle, grandparent, an adult who is the child of a waiver participant, first cousin, or step-family member.

(c) A participant's spouse or legally appointed guardian may not directly or indirectly receive reimbursement for providing waiver services for their ward unless the guardian presents the Division with a certified copy of a court order establishing guardianship under the terms described by W.S. 3-2-107(b). Direct or indirect reimbursement shall include, but is not limited to, providing direct services at or serving as the owner or officer of a provider organization serving the ward, residing in a provider owned facility serving the participant, or being married to a person providing waiver services to the participant.

(d) To provide waiver services to a related participant, the relative shall:

(i) Form a Limited Liability Company (LLC) or other corporation, and

(ii) Maintain provider certification in accordance with this chapter.

(e) Services that a relative provider may provide include case management, independent support brokerage, respite, companion, residential habilitation, supported living, specialized equipment, any supported employment service, prevocational services, and environmental modifications with the following limitations:

(i) For residential habilitation, the parent or stepparent cannot live in same residence as participant.

(ii) Personal care and supported living services reimbursed to a relative provider cannot exceed four (4) hours per day if the provider lives in the same residence as the participant.

(iii) A provider who is the parent, stepparent, or legally authorized representative of a participant age zero through seventeen may only be reimbursed for providing personal care services up to four (4) hours per day and for extraordinary care purposes only. No other waiver services are reimbursable.

(A) Extraordinary care personal care services must align with the needs and supports specified in the plan of care which demonstrate the need for extraordinary care, and

(B) The participant's Adaptive Behavior Quotient must be 0.35 or lower on the Inventory for Client and Agency Planning (ICAP) assessment; and meet one of the following criteria:

(1) The participant needs assistance with Activities of Daily living (ADLs) or Instrumental Activities of Daily Living (IADLs) exceeding the range of expected activities that a legally responsible individual would ordinarily perform in the household on behalf of a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization; or

(2) The participant requires care from a person with specialized medical skills relating to the participant's diagnosis or medical condition as determined appropriate by the participant's physician and the Behavioral Health Division.

(f) If a parent, stepparent, or legally authorized representative is providing personal care to his or her ward, the plan of care shall be developed and monitored by a case manager without a conflict of interest.

(g) If the relative provider is not providing services in the best interest of the participant, the case manager shall work with the participant and appropriate team members, and the Division as needed, to choose other providers as appropriate and modify the plan of care to better suit the needs of the participant.

(h) A Participant age eighteen (18) or older or his or her legally authorized representative who is self-directing waiver services may hire a relative to provide waiver services listed in subsection (e) if:

(i) The parent or stepparent is not the participant's Employer of Record or legal guardian,

(ii) The participant receives independent support brokerage,

(iii) The participant hires a parent or stepparent for services specified in subsection (e),

(iv) The employer of record provides supervision and oversight of employees and ensures claims are submitted only for services rendered that align with the approved plan of care, and

(v) The Financial Management Service subagent ensures that claims are submitted only for services authorized in the self-directed budget allocated by case managers.

(i) Payment to any relative specified in subsections (e) and (f) shall only be made when the service provided is not a function that the relative would normally provide for the individual without charge as a matter of course in the usual relationship among family members; and the service would otherwise need to be provided by a qualified provider.

(j) Any relative who provides services either as an owner, employee, officer of a provider or who intends to provide services to a related waiver participant shall disclose the relationship in the participant's team meeting and acknowledge and address the safeguards set forth in documentation required by the Division.

(k) If a provider permits the hiring of a guardian of a participant receiving services from the provider, or if a provider permits the hiring of relatives of provider employees working for the organization, the provider shall have a written policy on how it addresses potential conflicts that arise from these relationships, how the conflict of interest is mitigated, and the policy is shared with the participant and legally authorized representative(s).

Section 32. Interpretation of Chapter.

(a) The order in which the provisions of this Chapter appear is not to be construed to mean that any one provision is more or less important than any other provision.

(b) The text of this Chapter shall control the titles of its various provisions.

Section 33. Superseding Effect. This Chapter supersedes all prior rules or policy statements issued by the Division, including Provider Manuals and Provider Bulletins, which are inconsistent with this Chapter.

Section 34. Severability. If any portion of this Chapter is found invalid or unenforceable, the remainder shall continue in full force and effect.